

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-009557

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1764

STATE FILE NUMBER

FILED FEB 28 1963

|  |                           |  |                               |
|--|---------------------------|--|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY   |                               |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>St. Louis   |                           | c. CITY OR TOWN St. Louis  |                               |
| Length of stay in lb<br>71 yrs   |                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION HAMILTON MEDICAL CENTER   |                           | d. STREET ADDRESS (If outside, give location)<br>4623 Leona Street.  |                               |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                           | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                               |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>OSCAR GEORGE VON ROHR  |                           | 4. DATE OF DEATH<br>Month Day Year<br>February 16, 1963  |                               |
| 5. SEX<br>male   | 6. COLOR OR RACE<br>white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br>3/12/1885 |
| 9. AGE (last birthday)<br>77   |                           | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>maintenance man   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>building  |                               |
| 11. BIRTHPLACE (City and state or country)<br>Highland, Illinois   |                           | 12. CITIZEN OF WHAT COUNTRY<br>USA   |                               |
| 13a. FATHER'S NAME<br>Henry Von Rohr   |                           | 13b. MOTHER'S MAIDEN NAME<br>Louise Koehler  |                               |
| 14. NAME OF HUSBAND OR WIFE<br>Lena Braun  |                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>no  |                               |
| 16. SOCIAL SECURITY NO.<br>3   |                           | 17. INFORMANT<br>Mrs. Morrell T. Caldwell, 4645 Fendler Ct.  |                               |
| 18. CAUSE OF DEATH (Enter only one cause)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis<br>generalized arteriosclerosis<br>332X<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |                           | INTERVAL BETWEEN ONSET AND DEATH<br>2 days   |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |                           | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                               |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                               |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                           | 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                               |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                           | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                               |
| 20f. CITY, TOWN, OR LOCATION<br>St. Louis  |                           | COUNTY STATE   |                               |
| 21. I attended the deceased from Nov. 10, 1962 to Feb 16, 1963 and last saw him alive on Feb 15, 1963<br>Death occurred at 6:05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.  |                           | 22a. SIGNATURE (Degree or title)<br>G. F. Montgomery M.D.  |                               |
| 22b. ADDRESS<br>1105 Central Clayton St.   |                           | 22c. DATE SIGNED<br>2/16/63  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>removal   |                           | 23b. DATE<br>2/19/63   |                               |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Lakewood Park Cemetery   |                           | 23d. LOCATION (City, town, or county)<br>St. Louis County, Missouri  |                               |
| 24. FUNERAL DIRECTOR<br>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.  |                           | 25. DATE RECD. BY LOCAL REG.<br>FEB 18 1963  |                               |
| 26. REGISTRAR'S SIGNATURE<br>Paul Smith M.D.   |                           |  |                               |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR  
TYPEWRITER RIBBON

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Rev. 4/59

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Dr. Austin F. Montgomery  
110 S. Central  
Sat. 10:30 to 12 noon

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Harmon H. Fritz*

Licensed Embalmer No. 3882

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.